



Facilities & Services Licensing
Construction Review Services
2725 Harrison Avenue NW Suite 500
Olympia, Washington 98502
Telephone: (360) 705-6778
Fax: (360) 705-6654
Internet: www.doh.wa.gov/hsqa/fsl/crs.htm

For Office Use Only

Check No.	Amount	Facility ID No.	CRS Project No.
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1 Project Information	Facility Name		Project Title			
	Project <u>Site</u> Address		City	County	State WA	Zip
	Type of Facility <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Home <input type="checkbox"/> Ambulatory Surgery Cntr. (ASC) <input type="checkbox"/> Hospice Care Center		<input type="checkbox"/> Correctional Facility <input type="checkbox"/> Alcohol Treatment Facility (ATF) <input type="checkbox"/> Private Psychiatric Hospital <input type="checkbox"/> Birthing Center		<input type="checkbox"/> Boarding Home <input type="checkbox"/> Boarding Home w/ Assisted Living Services (Chapter 388-110 WAC) <input type="checkbox"/> Treatment Facilities For Psych. Impaired Children And Youth (PICY) <input type="checkbox"/> Adult Residential Rehabilitation Center (ARRC)	
	Building Permit Jurisdiction:					
	Project Description:					
	<input type="checkbox"/> Check if this project is for new carpet only					

2 Facility Info.	Owner / Facility Name		Do you prefer to receive communications via: <input type="checkbox"/> Email <input type="checkbox"/> Postal Service <input type="checkbox"/> Fax			
	Owner / Facility <u>Mailing</u> Address		City	State	Zip	
	Facility Telephone	Facility Fax				
	Facility Administrator <input type="checkbox"/> Mr. <input type="checkbox"/> Ms.		Telephone	Administrator's Email Address:		
	Facility Contact <input type="checkbox"/> Mr. <input type="checkbox"/> Ms.		Telephone	Facility Contact Email Address:		

3 Consultant	Consultant (architect/engineer) Firm's Name		Do you prefer to receive communications via: <input type="checkbox"/> Email <input type="checkbox"/> Postal Service <input type="checkbox"/> Fax			
	Consultant Firm's <u>Mailing</u> Address		City	State	Zip	
	Consultant's Telephone	Consultant's Fax				
	Consultant's Project Contact <input type="checkbox"/> Mr. <input type="checkbox"/> Ms		Consultant's email Address			

4 Project Cost	Project Cost Estimate: See WAC 246-314-010(4)		For Hospitals, Psychiatric Hospitals, Nursing Homes, Hospice Care Centers and Ambulatory Surgery Centers <u>only</u>. Fill out portions below for projects that require Certificate of Need (CON) approval.	
	New Construction			
	Alterations / Renovation		Current number of licensed beds.	
	Fixed Installed equipment		Number of licensed beds added in this project.	
	Other costs including A/E fees		Total proposed number licensed beds.	
	Total of above		Attach a copy of the Certificate of Need or Determination of Non-Reviewability. See Instructions on Back.	
	Estimated date of occupancy			

5	Signature	Title	Date
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- Include payment, two copies of the plans, and one copy of the functional program, with the completed application.
- Please make checks payable to **Department of Health**.
- **Note: Incomplete applications will be returned without review.**

Instructions for completing the Department of Health Construction Review Application

Block 1 – Project information

- Fill in the facility name. The facility name should match the name given to the department in previous applications and should be the same as indicated on the facility license (if currently licensed).
- Enter the project title. The project title will identify the work to be performed, will remain the same through out the project and should be a limited number of characters. All submissions shall be identified by the facility name and project title.
- Enter the physical address of the location where the construction or renovation will occur.
- Check the most appropriate type of facility. A separate application and set of documents shall be submitted for projects containing multiple facility types. The documents should clearly identify which areas are to be included under which facility type.
- Construction Review Services (CRS) works closely with the local building jurisdiction. Please provide the name of the local building jurisdiction. In some cases there may be two local agencies that have jurisdiction. Please provide both jurisdictions.
- Enter a brief project description. For renovations include the location within the facility where the renovation will occur i.e. third floor, west wing etc.

Block 2 – Facility information

- Enter the administrator name. This should be the same as indicated on the application for the facility license.
- Enter the email address, if available. To save time, CRS will often email review comments to the project team members.

Block 3 – Consultant

- The consultant is the architect or engineer that will be assisting you with your project. We strongly recommend the services of a architect or engineer be used as early in the project as possible. Licensing regulations require most facilities drawings to be stamped and signed by an architect or engineer registered in the state of Washington.

Block 4 – Project Cost.

- Review WAC 246-314-010(4) for the definition of project cost. Enter the estimated cost for new construction and alterations / renovations on the appropriate lines. Project cost shall include the cost of all project related costs except taxes. Certain equipment costs may be waived from being included in the construction cost upon the approval of Construction Review Services. A request shall be made to CRS in writing before the approval can be granted. Enter the estimated date in which the space will be occupied for its intended use. For a project that requires Certificate of Need approval, fill in the appropriate information, for Hospitals, Psychiatric Hospitals, Hospice Care Centers, Ambulatory Surgery Centers and Nursing Homes Only. By signing this application you attest that you have verified the applicability of Certificate of Need and the information provided is accurate.

Block 5

- Sign and date the application. Include your title in relation to the project i.e. Architect, Project Manager, Engineer, Administrator etc.